

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **22075**

FILED JUL 7 1949

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **6076** Registrar's No. **1487**

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission).	
a. COUNTY <b>St. Louis</b>	a. STATE <b>Mo.</b>	b. COUNTY <b>St. Louis</b>	b. COUNTY
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Koch</b>	c. LENGTH OF STAY (In this place) <b>2 1/2 mo</b>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Robert Koch Hospital</b>	d. STREET ADDRESS (If rural, give location) <b>5922 MARWINETTE</b>		

<b>3. NAME OF DECEASED</b> (Type or Print)			<b>4. DATE OF DEATH</b> (Month) (Day) (Year)		
a. (First) <b>Peter</b>	b. (Middle) <b>James</b>	c. (Last) <b>Dolan</b>	<b>6-21-49</b>		
<b>5. SEX</b> <b>MO</b>	<b>6. COLOR OR RACE</b> <b>W</b>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)</b> <b>MARRIED</b>	<b>8. DATE OF BIRTH</b> <b>9-26-80</b>	<b>9. AGE</b> (In years last birthday) <b>68</b>	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>SALESMAN</b>	<b>11. BIRTHPLACE</b> (State or foreign country) <b>St. Louis, Mo U</b>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		

<b>13a. FATHER'S NAME</b> <b>John Dolan</b>	<b>13b. MOTHER'S MAIDEN NAME</b> <b>MARY MARLOFF</b>	<b>14. NAME OF HUSBAND OR WIFE</b> <b>Chrystie Dolan</b>
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)	<b>16. SOCIAL SECURITY NO.</b> <b>488-01-1384A</b>	<b>17. INFORMANT'S SIGNATURE OR NAME</b> <b>Hospital Records</b>	<b>ADDRESS</b> <b>Koch, Mo.</b>
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<b>18. CAUSE OF DEATH</b> Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	<b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) <b>Chronic Pulmonary Tuberculosis</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>?</b>
	<b>ANCEDECENT CAUSES</b> <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i>		
	<b>II. OTHER SIGNIFICANT CONDITIONS</b> <i>Conditions contributing to the death but not related to the disease or condition causing death.</i> <b>Arteriosclerotic Heart Disease</b>		
<b>19a. DATE OF OPERATION</b>	<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify)	<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b>
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (m.)	<b>21e. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>21f. HOW DID INJURY OCCUR?</b>

**22. I hereby certify that I attended the deceased from 4-5, 1949, to 6-21, 1949, that I last saw the deceased alive on 6-21, 1949, and that death occurred at 3:20 A.M., from the causes and on the date stated above.**

<b>23a. SIGNATURE</b> (Degree or title) <b>John Mederunner, M.D.</b>	<b>23b. ADDRESS</b> <b>Koch, Mo</b>	<b>23c. DATE SIGNED</b> <b>6-21-49</b>
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<b>24a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>	<b>24b. DATE</b> <b>6-25-1949</b>	<b>24c. NAME OF CEMETERY OR CREMATORY</b> <b>Park Lawn Cemetery</b>	<b>24d. LOCATION</b> (City, town, or county) (State) <b>St. Louis, Mo.</b>
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<b>DATE REC'D BY LOCAL REG.</b> <b>6-23-49</b>	<b>REGISTRAR'S SIGNATURE</b> <b>Herbert R. Dombrowski</b>	<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Weick Bro. Und. Co.</b>	<b>ADDRESS</b> <b>2201 S. Grand</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

..... Student Embalmer No. ....

working under my personal supervision.

Signed.....

*James R. Dunn*

Signed.....  
Student Embalmer

Licensed Embalmer No. *4527*

P. O. Address *2201 S. Grand*

**Note:** The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.